

KRS Bidder Conference Call Q & A

May 26, 2009

Bidder Questions

1. Can a copy of the RFP be provided in a Word document?

A: On May 12, 2009 the document provided on the KRS website was updated with a Microsoft word version.

2. Will you be providing detailed claims data?

A: Detailed de-identified claims, without pricing elements will be provided to the finalist bidders for re-pricing and best and final offer preparation.

3. *Payment for Services. 2. Method of Payment. . .KRS will make every reasonable effort to make payments within 30 business days after receipt of a properly supported invoice.*

- Does this payment timeframe apply to reimbursement of pharmacy claims paid by the PBM on KRS' behalf? If not, what timeframe would apply to our biweekly claims invoices?

A: No, reimbursement of pharmacy claims paid by the PBM on KRS' behalf should meet the standards as defined in MIPPA regulation. KRS' payment timeframe for payment of bi-weekly invoices is within 15 days of receipt of the invoice.

4. *Plan Benefit Overview. Calendar Year 2008 statistics .Average Persons Per Month- 28,000; Number of Eligible Retirees – 42,960*

- Please reconcile this difference. Does it mean that 14,960 Eligible Retirees do not participate in the drug program?

A: Yes, for the 2009 plan year there was an average of 14,960 eligible retirees that did not participate in the prescription benefit program.

5. What is the patient to member ratio? If there are 28,218 patients (utilizing members), how many total members are covered under the plan today?

A: The enrollments are all single member contracts. There are 42,960 members eligible for benefits.

6. Is there a claims detail file available?

A: Detailed de-identified claims, without pricing elements will be provided to the finalist bidders for re-pricing and best and final offer preparation.

7. Will the contracted vendor manage the eligibility interface with CMS?

A: KRS would entertain a contracted vendor to manage the eligibility interface if the contracted vendor were able to administer the enrollment according to KRS requirements and consistent with CMS employer group requirements.

8. Will KRS have their own P&T Committee? Will KRS use vendor's formulary?

A: The answer is No to both questions. KRS will require P&T Committee support from the selected PBA. KRS has an open formulary with exclusion of certain drug coverage categories. KRS has already submitted formulary information as required by CMS for 2010. The selected PBA will be required to administer the program as it was submitted to CMS and support the KRS process with their P&T committee.

9. Who will handle the formulary file submission process?

A: KRS, working with their Pharmacy Benefit Consultant, will handle the formulary file submission to CMS and maintenance of the formulary file on KRS' behalf.

10. Will KRS bill member's premium or will the vendor be expected to bill?

A: KRS will handle the billing of member premium.

11. Per Q21 below – Please confirm what is being asked to be disclosed?

21. PBA agrees to provide full disclosure and provide 100% pass through to KRS by making available all electronic claims data and other relevant financial transaction records specific to KRS and allow such records to be audited by KRS or their designated auditor. In addition, PBA will allow full access to any and all contracts, documents and agreements maintained with drug manufacturers, wholesalers, retailers, mail order, affiliates, subsidiaries, subcontractors or other entities involved in financial transactions related to claim activity directly or indirectly attributable to KRS and allow these records to be used in connection with an audit.

Yes No

A: KRS is asking each bidding PBA if it is willing to disclose all pharmacy contracted rates, dispensing fees and other fees that may apply to contracted provider pharmacies. In addition, KRS expects the PBA to be willing to provide all claims data and other relevant financial transaction

records specific to KRS; full access to any and all contracts, documents and agreements maintained with drug manufacturers, wholesalers, retailers, mail order subcontractors and all other downstream and related entities involved in financial transactions related either directly or indirectly to KRS claim activity. KRS' expectation is that the PBA shall only receive financial benefit through the administrative fees paid by KRS to the PBA.

12. Will there be a benefit that covers members that are not eligible for Medicare Part D?

A: No, the KRS plan only provides coverage to Medicare eligible beneficiaries.

13. Will component pricing for services be accepted?

A: Although inclusive administrative fee pricing is preferred, yes component pricing will be accepted.

14. What is expected in terms of disclosure of revenue streams? Does mail service acquisition pricing need to be disclosed?

A: In a change to the final rule, §423.100 published in the Federal Register on January 21, 2009, the definition of negotiated price changed effective January 2010. This change requires Part D sponsors to base beneficiary cost sharing and price reporting to CMS on the price ultimately received by the pharmacy or other dispensing provider, also known as the pass-through price. KRS will expect each bidding PBA to comply with this CMS requirement.

Will a census file be provided?

A: A zip code file of covered members as of the RFP date was provided as attachment D in the request for proposal.

15. The below standards are not in line with Med D access requirements. Do we need to run the GeoAccess report as requested and also in line with Med D access requirements?

I. NETWORK / MAIL ORDER PHARMACY REQUIREMENTS

1. Adequate access will provide 95% of the population in urban areas, a pharmacy within 1 mile and 95% of the population in rural areas, a pharmacy within 5 miles a network of 99% of the current pharmacy providers currently providing at least one claim for a covered KRS member.

Please provide GEO Access analyses Medicare Subscribers utilizing the Zip Code files at Attachment D.

A: The Geo Access report provided by the selected vendor will be used to satisfy the submission requirement with CMS. Therefore, we will relax our original bidder network access requirements to meet the Tri-Care standards as required by CMS. The revised access standards will be provided in the written Q&A documentation provided to all bidders.

- **In urban areas, at least 90 percent of Medicare beneficiaries in the Applicant's service area, on average, live within 2 miles of a retail pharmacy participating in the Applicant's network;**
- **In suburban areas, at least 90 percent of Medicare beneficiaries in the Applicant's service area, on average, live within 5 miles of a retail pharmacy participating in the Applicant's network; and**
- **In rural areas, at least 70 percent of Medicare beneficiaries in the Applicant's service area, on average, live within 15 miles of a retail pharmacy participating in the Applicant's network.**

Note: Applicants may count I/T/U pharmacies and pharmacies operated by Federally Qualified Health Centers and Rural Health Centers towards the standards of convenient access to retail pharmacy networks.

16. RFP Page 14., Section IV. General Requirements, Question 9: "KRS has many years' experience with contracting for PBA services. KRS has developed, through this time, a contract document that will be the basis for contracting with a selected PBA vendor. Confirm that your company will accept a KRS provided vendor agreement as the basis of a contract and also be willing to attach the response to this RFP as an addendum to that contract."

- We request a copy of KRS' contract document/vendor agreement.

A: A copy of KRS' contract document/vendor agreement will be provided to the finalists as part of the best and final offer and vendor selection processes.

17. Attachment A, Pricing Proposal Worksheet.

- We request the most recent 12 months of claims data from KRS to customize our response to Attachment A, the Pricing Proposal Worksheet.

A: The pricing proposal should contain pass through pricing rates for groups the size and composition of KRS based on each PBA's experience. As stated in previous questions, detailed de-identified claims, without pricing elements will be provided to the finalist bidders for preparation of their best and final offer.

18. We request KRS' current Generic Effective Rate (GER) and current Generic Dispensing Rate (GDR).

A: Detailed de-identified claims, without pricing elements will be provided to the finalists for re-pricing. Summary level generic claim information is provided below.

Claim Type	Brand	Generic	Specialty
Retail Network Claims			
Claim Count percentage	32.29%	65.41%	.725%
Claim Cost Percentage	65.86%	21.01%	6.78%
Mail Pharmacy Claims			
Claim Count percentage	.63%	.94%	.009%
Claim Cost Percentage	2.77%	1.05%	.17%

19. Attachment B, it states, "If a claim for a brand name medication is submitted when an equivalent generic medication is available, for any reason, the participants' copayment will be the generic copay plus the difference in plan cost between the brand and generic item if a brand is submitted for any reason the member will pay the difference between the brand and generic."

RFP Page 22, Plan Design Requirements, Item #2, it states, "the member to pay the difference in cost between the brand and generic plus the generic copayment whenever a member selects a brand drug when a generic is available."

- Will the member pay the cost difference between the brand and the generic if the physician authorizes the brand?

A: As the plan design is administered today, no, members would not pay the difference in cost if the brand is approved by their physician. The

bidder should indicate their ability to handle these, and other, various copayment options, explaining how copay exceptions are handled.

20. Can Performance Guarantee be measured in the aggregate?

A: No, KRS is expecting the PBA to pass or fail each performance guarantee individually based on their performance of each measured goal.

21. Page 13, Section IV Q#2, "No commissions are incorporated in the quoted pricing including, but not limited to: administration fee for retail POS, retail direct member reimbursement (paper/manual), and/or mail service or any other fee or charge being proposed." Please clarify. Is this relating to the PBM or a subcontractor of the PBM?

A: Both

22. Page 25 Section VII Q#B "The ability to identify the effective network pharmacies, more than just financial performance, and report the outlier performers to KRS. Describe exception reporting and communications to provider outliers to change negative provider habits." Please clarify.

A: The PBA should have a process to monitor both financial and service performance of its contracted pharmacies. In addition, the PBA should be able to provide KRS with a report of pharmacies that are performing poorly and pharmacies that are performing at or above PBA expected standards. The PBA should have a process to address poor performers as they are identified.

23. Page 31 Section IX Q# 19, "Are you able to support a custom specialty pharmacy program?" Please clarify your meaning of custom specialty pharmacy program.

A: Please state whether or not you are able to support a specialty program in which KRS would have the ability to customize the products that are designated as "specialty" pharmaceuticals as well as the ability to customize a provider network that are considered specialty providers.

24. Why is KRS out to bid? What is the current satisfaction level with WHI?

A: KRS has contracted with Walgreens Health Initiatives for 4 years. KRS has submitted an application with CMS for a direct contracted employer group waiver plan for year 2010, which significantly changed KRS' requirements from a PBA. Therefore, KRS felt it necessary to request bids for these expanded services.

25. Will detailed claims data be provided? If not, can summary level data that includes total scripts for Mail/retail/90-day and brand/generic be provided? The data provided within the RFP does not have the brand/generic breakdown.

A: Detailed de-identified claims, without pricing elements will be provided to the finalist bidders for re-pricing. Summary level utilization information has been provided in response to a previous question.

26. Page 7 of the RFP "Method of Payment" states that "KRS will make every reasonable effort to make payments within 30 business days". Please confirm whether the 30-day lag will be for only the administrative fee or for both the administrative fee and claim payments to pharmacies. As you are aware most PBMs pay pharmacies on behalf of their clients twice a month.

A: KRS' payment timeframe for payment of bi-weekly claims invoices is within 15 days of receipt of the invoice.

27. Page 10 A, "Proposer Response and Proprietary Information" - Please confirm that the pass-through discounts and dispensing fees, rebates, administrative fee, MAC list, pharmacy contracts, and network contracts fit under the definition of "selected financial data" that will be protected if the Proposer declares and designates this information proprietary.

A: Yes, if designated as propriety by the bidder in their proposal, these types of information would be considered confidential.

28. Would KRS seriously consider a limited network as a cost savings measure?

A: KRS has filed with CMS as a national plan as required by CMS for direct contracted employer groups. However, KRS did exclude the US territories of Puerto Rico, Guam, US Virgin Islands, American Samoa and the Northern Mariana Islands from their network coverage requirements. KRS is always open to review cost savings measures, but the decision to review a limited pharmacy network is not contemplated by this RFP.

29. On page 11, D: Proposer Components 3rd bullet, states "A listing of any contracts with any other entities to provide services related to pharmacy or health benefits management and a list of references for such engagements. Submit specific Direct Contract EGWP applications that have been submitted to CMS".

Are you looking for applications that we have submitted or by clients that we have serviced?

A: We are wanting to know, as a part of your references, if there are any other Direct Contract Employer Group Waiver Plans that you support today or that you have supported in the application process.

30. Can we get a copy of the formulary that we would be administering for 2010? Would you be able to provide the Health Plan Management system formulary file? Will you be submitting a copy of the rules that were submitted to the finalists?

A: At this stage of the RFP response, we want you to know that we are submitting the formulary and it will have all the CMS requirements built into it. The question is whether you can support the formulary process with your P&T committee. The finalists will receive a copy of the formulary. Since administrative processes for handling utilization management programs are PBA specific, the finalists will not receive the current Utilization management criteria with this formulary as it is proprietary to the current pharmacy benefit administrator, but the file will indicate the drugs that require utilization management processes.

31. With 2010, CMS is requiring that pharmacies be paid within 15 days of a clean claim. Would KRS be willing or consider putting up an escrow to pay claims out of?

A: This is how KRS currently manages the benefit, through funding of an escrow account.

32. On the pricing, regarding the rebate estimates. This would be difficult to give, without seeing utilization and formulary. Are you looking for this pricing if we become a best and final or do you want to see that pricing before-hand?

A: We are looking for your best determination of what these estimates would be based on each PBA experience with groups the size and type as KRS. Specific KRS data will be provided to those selected as finalist bidders for them to fine-tune their pricing as part of the best and final offer process.